DATE OF QUESTION	QUESTION	ANSWERS
12/21/05	1.4 Special Team reviews in Value Options has a limit of 3-5, there is no limit to these noted, just stated infrequently. They take a lot of time to do, meeting with the provider, reviewing the chart, attending a treatment team, even when done at a minimal level, this takes time away from the same staff doing the auths. We need a limited number they can request then we can set the number we will initiate on our end, better control of our workday and staffing patterns.	DMA RFP indicated that only 2 were done in the past 3 years statewide
12/21/05	1.4 of Criteria for Approval: A) Can a position such as the Medical Director or Psychologist position be part-time LME and Part-time service side as long as there is a clear division of time and funding? B) Can the Child and Adolescent psychiatrist position be the same person as LME Medical Director? C) Can we use a contracted physician for the Child and Adolescent Psychiatrist?	A. Medical Director (MD with NC license and board certified in psychiatry) must be full-time on UR functions, including appeals, etc. Other UR positions could be part-time, but separation between service and UR would be very tricky. B. Yes C. Yes
12/19/05	1.4 The requirements do not seem to make any distinction between Medicaid and state-funded services, and many of those listed seem to be Medicaid's. Are requirements for managing both groups of services the same or are there some differences?	Expectations re staffing and most processes are same for Medicaid & State.
12/21/05	We were quite pleased to see the correction regarding the l:35 that came out today (though we regretted the time spent on unnecessary research into Medicaid eligibility for our 16 county alliance) but to be clear, does that include support staff, leadership, medical director as well as UR clinicians?	Clarification that it is staff to 35,000 population- not covered lives. Applies to professional UR staff - not support staff
12/21/05	Section l.6 stipulates that ANY review decision that results in denial/suspension/reduction…shall be made only after a case review by psychiatrist. This seems unreasonable to tie up a costly resource (doc time) with suspensions, reductions and it seems at odds with other policy guidance regarding doc review only of Denials. Could this be a typo?	Clarification: Any review decision that results in the denial of a service during the concurrent review process shall be made only after case review by the UR LME's psychiatrists and consultations (peer to peer reviews) between the UR LME's psychiatrists and the primary provider. Furthermore, the UR LME's psychiatrist shall be a child/adolescent psychiatrist if the recipient is under twenty-one.

12/21/05	1.8 This is new, when will we see these checklists? Everyone uses their own, depending on the questions that must be reviewed and answered, depends on the speed at which we can do auths.	A template for the PCP Checklist (Review of the Person Centered Plan Components) is included with this transmittal in an Excel file entitled "PCP Review Tool-1.xls"
12/21/05	2.1 PCP Review and care coordination - Will it still remain at the LME?	PCP review will be done by the LME that is performing UR for the regional coverage area. Care coordination function will remain as a function of each individual LME.
12/28/05	2.1 Who is responsible for the development and review of the PCP as it relates to UR?	The PCP is developed by the provider agency which serves as the consumer's clinical home (Targeted Case Management provider for DD consumers, usually the Community Support provider for MH/SA consumers). The PCP must be developed with the consumer and all others that he/she wants to have included in the process. The local LME may want to involve its care coordination staff during the PCP development for high risk/high cost individuals. Review of the PCP as it relates to UR is the responsibility of the regional UR LME.
12/22/05	Section 2.2 - We need more clarity on what this section means since several of us interpreted it various ways?	The purpose of reauthorization/concurrent reviews is to establish if the authorized service continues to be appropriate at the current level and if not, what alternative services are to be considered. Services shall be reviewed at least two State business days prior to the expiration of the previous authorization.
12/21/05	2.3 Are they talking about Access here or UM, who is being measured on the answer in 5 rings and return provider calls within 2 hours. Feedback has been that this is Access but UM and Provider Relations are the ones that take most of the provider calls.	This section refers to UR responsiveness
12/22/05	Section 4.1 - Define the UR guidelines for state and state allocated funds or give reference. Also - Does this imply that each LME will create it's own benefit packages that the UM vendor will be accountable to use when approving state dollars?	Each LME is expected to develop a Resource Use Plan for its State allocated funds. This plan will be used by the regional UR LME in the UR process. DMH/DD/SAS will be issuing guidance on the development of the State Resource Use Plans. Note that UR for State funds will not begin until 7/1/06.

12/22/05	Section 5.5 - We need clarity on what is the "state vendor"? Also define "post payment"?	The statewide UR contractor (Value Options) will perform post payment reviews on a random sample of services to establish whether the services were (1) delivered in a manner consistent with the purpose for which they were authorized, (2) the least restrictive and most cost effective service option which appropriately addressed the need for which the services were authorized, and (3) medically necessary.
12/21/05	Section 5.6 says we will attend quarterly advisory committee meetings: I assume you are speaking to groupings the Division will form of the lead UR LMEs that we will commit to attending, correct? Is this with Value Options or the Division?	Quarterly meetings refers to meetings with DMA, DMH/DD/SAS, the statewide vendor and others with UR responsibilities.
12/19/05	5.7 references adherence to record retention requirements. Where do we find UM (as opposed to treatment) record requirements?	Follow DHHS financial records retention policies
12/19/05	7.1 states that staff doing local approval of DD plans have masters degrees; this has not been a requirement before now, and indeed most DD services are overseen and managed by people with bachelors degrees and experience. Is it correct that Masters degrees will be required?	Yes. Masters degree in a human service field and a minimum of 2 years of postgraduate experience with the developmental disabilities population will be required for approval of CAP-MR/DD plans. LMEs had earlier questioned whether a license was necessary for DD and it is not, but a Master's degree will be required. The Master's degree requirement also applies to nurses.
12/21/05	8.0-11.0 Are they reviewing the LME's 8-5 Access (looks like it in the questions on the application) and the same LME's ability to perform the regional after-hours STR?	The Regional LME will do all telephonic STR for its coverage region. Each individual LME shall have 8 to 5 walk-in face-to-face STR capacity.
12/21/05	Section 8.3 requires that qualified professionals perform STR and that we submit their resumes. Again, since you specifically discuss daytime in the NOTE, do you want all of our STR vitas (daytime) plus our after hours contracted, or do you only want after hrs STR vitas?	Resumes should be submitted for the staff who will be doing telephonic STR for the regional coverage area. Telephonic STR is 24/7/365
12/21/05	Section 9.0 screening in the application directly follows a statement regarding screening F-F 8-5 by the LME. Yet, 9.0 we assume is in fact referring to the after hours screening piece only, and not the daytime piece, are we correct in that understanding?	The Regional LME will do all telephonic STR for its coverage region. Each individual LME shall have 8 to 5 walk-in face-to-face STR capacity.

12/22/05	Section 10.1 - Please further explain what this means - is not consistent with performance agreement requirement for emergent requests. Does not mention or talk about face to face response required?	This refers only to telephonic screening to determine if an emergency exists. A "warm transfer" is made to the local LME crisis service provider for triage and, if indicated, face-to-face assessment and service provision at the local level in accordance with the performance contract.
12/19/05	12. How and how quickly, will we receive information about the number of Medicaid enrollees in the various LME regions? Staffing and costs cannot be projected until we have that information.	That information is included with this transmittal in an Excel file entitled "UR_STR Data.xls."
12/18/05	12. Cost As LMEs prepare to submit to be a UR vendor, how folks develop their costs will need to be standardized. The LME cost model is only a theoretical one and what folks truly include in their costs and what the measure will be should be the same. It is important to compare apples to apples on this one. I'd suggest that DMH provide a standard formula/format for all to follow in presenting their costs. This will properly account for what it will take and assure that all are using similar information.	A template for the cost proposal is included with this transmittal in an Excel file entitled "UR_STR Cost Proposal-1.xls."
12/19/05	Is it still an option for an LME within a region to apply for only one of the 2 functions (i.e. just UR or just STR)?	This was never envisioned as an option, except in very unusual situations that would require clear justification in the application.
12/19/05	If so, do they complete the applicable components of the application accordingly or is the application to be completed in its entirety?	In this unusual situation, we would expect one application covering both UR and STR with the LME submitting the application describing the capacity and role and agreement of the LME that would act as a subcontractor.
12/21/05	With the UR process, can the LME from which a service originates be a part of the appeals process for services that are terminated, reduced, denied, etc. by the lead LME that is the authorizing body?	If this is it a firewall question, no entity that has a role in providing a service can participate in any UR or appeals process related to the UR decision. If this question means to ask whether a local (non-UR) LME can be a party to a Regional LME UR decision being appealed, the answer is no, unless the LME is the service provider.
12/21/05	Do you have in mind a page limit?	No. The application should be concise but must include all required information. Extra credit will NOT be given for excessive wordiness.

12/19/05	**IT Issues.** A. During the last UR review, the IT staff were asked to submit the sample Medicaid Authorization file to Eric Johnson prior to the site visit. The current set of instructions states no such requirement. To be clear, please let me know if you would like us to submit the file to Eric again or if we should simply have it available during the site visit? B. Also, in reference to the Information Systems Requirements document, would you like a typed overview of our IT system and the prior approval business processes to be submitted in supplement to the Application for UR and STR? Or, should the Information Systems document be considered as only an outline for the site visit interview. I appreciate your help any information you may provide.	A. Submit file that shows that authorizations can be transmitted as part of your application. B. Submit, with your application, a typed overview that addresses all items in the Information Systems Requirements document.
12/21/05	Nowhere does it specifically discuss a site visit, but it alludes to visits in the URL/PA document. Is that a plan, and will that occur the week of the tenth? Will all applicants be visited or will there be a pre-screening based on the merits of the application?	Initial review will be based on the application. Site visits may be scheduled with LMEs that submitted approvable applications.
12/21/05	We were somewhat confused by the URL/PA document, and concluded it had a different set of techy writers than the rest of the application. Am I correct in interpreting that that is some sort of guidance for a site visit and no written response to that is required in the UR application?	A. Submit file that shows that authorizations can be transmitted as part of your application. B. Submit, with your application, a typed overview that addresses all items in the Information Systems Requirements document.
12/22/05	The Submittal ID shows VO. What should that be for our LME? I wouldn't think it would be VO since this is a sample file form Value Options.	This value should probably change for the new/proposed process. Each LME currently has a unique identifier in their base provider number….3404925, 3404944… Instead of using "VO" for this value we can use the last two digits of their base provider number. This way the field length remains the same and the value is unique.
12/22/05	For the Action ID (1 character) there are two categories that I don't understand. PRTF and RCC. What do those mean?	PRTF = Psychiatric Residential Treatment Facility, a specific type of child residential treament. RCC = Responsible Cost Center
12/22/05	What would we use for the four-character SUB-SEC-CODE?	SUB-SEC-CODE is always hard coded as VOI. (Value Option Input). I has NO relation to Provider. It is being used internally in the system, to identify PA transaction from VO after PA update process everyday.

12/22/05	The rest of the data elements are pretty much self-explanatory, except for the last REC ERROR FLAG. I'm not sure I fully understand that. It says that it occurs 21 times. What does that mean?	There are 21 allowable occurrences of the errors for the PA file. There will be 1 (one) reported error per line.